State of California

CERTIFICATION FOR SERIOUS INJURY OR ILLNESS OF COVERED SERVICEMEMBER FOR MILITARY FAMILY CAREGIVER LEAVE (FAMILY AND MEDICAL LEAVE ACT)

DPA 757 (New 10/09)

MILITARY CAREGIVER LEAVE

Part A: For Completion by the EMPLOYEE

Employee Name: (Last, First, Middle)	Daytime Contact Phone Number:
Division/Unit:	
Name of covered servicemember for whom employee is requesting Caregiver Leave: (Last, First, Middle)	
Your relationship to the covered servicemember: ☐ Spouse ☐ Parent ☐ Child ☐ Next of Kin	

Part B. Covered Servicemember Information

1. Is the covered servicemember a current member of the Regular Armed Forces, National Guard, Reserves, or a Veteran (a Veteran must have been a member of the armed Forces at any time within five (5) years preceding treatment)? ☐ Yes ☐ No
   If Yes and not a Veteran, please provide the covered servicemember's military branch, rank, and unit currently assigned to:

2. Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)? ☐ Yes ☐ No
   If Yes, please provide the name of the medical treatment facility or Unit:

3. Is the covered servicemember on the Temporary Disability Retired List? ☐ Yes ☐ No

Part C. Care to be Provided to the Covered Servicemember

1. Describe the care to be provided to the covered servicemember:

2. Estimate the amount of leave needed to provide care:

Part D. For Completion by the HEALTH CARE PROVIDER

For completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (VA) health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). **Please ensure that Parts A, B, and C above are completed before completing this section. Please be sure to sign and date the form on the last page.**

1. Health Care Provider's Name and Business Address (you may attach a business card in lieu of completing this section)

2. Please indicate whether you are a:
   ☐ DOD health care provider ☐ DOD TRICARE network authorized private health care provider
   ☐ VA health care provider ☐ DOD non-network TRICARE authorized private health care provider

3. Type of Practice/Medical Specialty:		4. License Number:
5. Telephone:	6. Fax:	7. Email:

Part E. Medical Status

1. Covered servicemember's medical condition is classified as: (Check One)
   ☐ **(VSI) Very seriously ill/injured** - illness/injury is of such a severity that life is imminently endangered. Family is requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)
   ☐ **(SI) Seriously ill/injured** - illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD health care providers.)
   ☐ **OTHER ill/injured** - a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.
   ☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such a leave is requested, you may be required to complete the applicable request form.)

2. Was the condition for which the covered servicemember is being treated incurred in line of duty on active duty in the armed forces? ☐ Yes ☐ No

3. Approximate date condition commenced:

4. Probable duration of condition and/or need for care:

5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? ☐ Yes ☐ No
   If yes, please describe the medical treatment, recuperation, or therapy:

Part F. Covered Servicemember's Need for Care by Family Member	
1.	Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? ☐ Yes ☐ No If Yes, estimate the beginning and ending dates for this period of time:
2.	Will the covered servicemember require periodic follow-up treatment appointments? ☐ Yes ☐ No If Yes, estimate the treatment schedule:
3.	Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? ☐ Yes ☐ No
4.	Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medication condition)? ☐ Yes ☐ No If Yes, please estimate the frequency and duration of the periodic care:

Part G. Signature	
Printed Name of Health Care Provider:	
Signature of Health Care Provider:	Date:

Privacy Notice

The Information Practices Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 92-579) requires this notice be provided when collecting personal information from individuals.